Complete Summary

GUIDELINE TITLE

Practice parameters for the detection of colorectal neoplasms.

BIBLIOGRAPHIC SOURCE(S)

American Society of Colon and Rectal Surgeons. Practice parameters for the detection of colorectal neoplasms. Arlington Heights (IL): American Society of Colon and Rectal Surgeons; 1999. 10 p. [65 references]

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Colorectal neoplasms

GUIDELINE CATEGORY

Screening

CLINICAL SPECIALTY

Colon and Rectal Surgery
Family Practice
Gastroenterology
Internal Medicine
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide uniform parameters for the screening and detection of colorectal neoplasms.

TARGET POPULATION

- Adults 50 years of age or older (universal screening)
- Individuals at moderate or high-risk for developing colorectal cancer (age range for screening: puberty to 50 years of age, depending on personal or family medical risk factors)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Digital rectal examination
2. Fecal occult blood testing
3. Flexible sigmoidoscopy
4. Total colon examination (colonoscopy or double contrast barium enema and proctosigmoidoscopy)
5. Genetic counseling; genetic testing

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not applicable

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

An interdisciplinary panel of 16 health care professionals from the fields of medicine, nursing, consumer advocacy, health care economics, behavioral sciences, and radiology evaluated the currently available evidence for colorectal cancer screening and made recommendations for physicians and the public. The panel studied 3,500 peer-reviewed published articles and analyzed 350 articles in detail specifically assessing the following: 1) performance of screening tests; 2) effectiveness of screening tests; 3) acceptability to patients; 4) cost-effectiveness; and 5) outcome. A computer simulation of the consequences of conducting the various screening strategies in the population was done to determine the risks and benefits of each test.

The guidelines made recommendations for people in two groups: average individuals and individuals at increased risk for developing colorectal cancer.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

The guideline development panel analyzed an Office of Technology Assessment study for screening average-risk individuals, which demonstrated that costs associated with colorectal cancer screening are within the range of cost-effectiveness commonly accepted for other tests, such as mammography.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Screening Guidelines:

Risk	Procedure	Onset (Age,yr)	Frequency
I. Low or Average - (65 to 75 % of people)	Digital Rectal Exam and one of the following:	50	Yearly
A. Asymptomatic - no risk factors	Fecal occult blood testing and flexible sigmoidoscopy	50	FOBT yearly Flex- sig every 5 years
B. Colorectal cancer in nonfirst-degree relatives	Total colon exam (colonoscopy or double contrast barium enema and proctosigmoidoscopy	50	Every 5 to 10 years
II. Moderate Risk - (20 to 30% of people)			
A. Colorectal cancer in first-degree relative, age 55 or younger, or two or more first degree relatives of any ages	Colonoscopy	40 or 10 yrs. before the youngest case in the family, whichever is earlier	Every 5 years
B. Colorectal cancer in a first-degree relative over the age of 55	Colonoscopy	50, or 10 yrs. before the age of the case, whichever is earlier	Every 5 to 10 years
C. Personal history of large (>1 cm) or multiple colorectal polyps of any size	Colonoscopy	One year after polypectomy	If recurrent polyps-1 year If normal-5 years
D. Personal history of colorectal malignancy - surveillance after resection	Colonoscopy	1 year after resection	If normal - 3 years If still normal - 5 years If abnormal -

for curative intent			as above
III. High Risk (6 to 8 % of people)			
A. Family history of hereditary adenomatous polyposis	Flexible Sigmoidoscopy; consider genetic counseling; consider genetic testing	12 to 14 (Puberty)	Every 1 to 2 years
B. Family history of hereditary nonpolyposis colon cancer	Colonoscopy; consider genetic counseling; consider genetic testing	21 to 40 40	Every 2 years Every year
C. Inflammatory bowel disease			
1. Left-side colitis	Colonoscopy	15 years after onset of disease	Every 1 to 2 years
2. Pancolitis	Colonoscopy	8 years after onset of disease	Every 1 to 2 years

FOBT = fecal occult blood testing; Flex-sig = flexible sigmoidoscopy

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Colorectal cancer screening may lead to the early detection of disease and thus a reduction in the morbidity and mortality associated with the disease.

- Risk stratification of the population allows selection of appropriate and effective screening procedures for individuals based on personal or family medical risk factors.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- It should be recognized that these guidelines should not be deemed inclusive of all proper methods of care or exclusive of methods of care reasonably directed to obtaining the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician in light of all of the circumstances presented by the individual patient.
- This practice parameter has been developed from sources believed to be reliable. The American Society of Colon and Rectal Surgeons makes no warranty, guaranty or representation whatsoever as to the absolute validity or sufficiency of any parameter, and the Society assumes no responsibility for the use or misuse of the material.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1999

GUIDELINE DEVELOPER(S)

American Society of Colon and Rectal Surgeons - Medical Specialty Society

SOURCE(S) OF FUNDING

Not stated

GUIDELINE COMMITTEE

Standards Task Force of the American Society of Colon and Rectal Surgeons

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Task Force Members: Drs. Clifford L. Simmang and Peter Senatore, Project Directors; Ann Lowry, Chair; Terry Hicks, Council Representative; Marcus Burnstein, Frederick Dentsman, Victor Fazio, Edward Glennon, Neil Hyman, Bruce Kerner, John Kilkenny, Richard Moore, Walter Peters, Theodore Ross, Paul Savoca, Anthony Vernava, W. Douglas Wong

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

An update is not in progress at this time.

GUIDELINE AVAILABILITY

Electronic copies: Available from the American Society of Colon and Rectal Surgeons (ASCRS) Web site.

Print copies: Available from the ASCRS, 85 W. Algonquin Road, Suite 550, Arlington Heights, Illinois 60005.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This summary was completed by ECRI on February 15, 2000. The information was verified by the guideline developer as November 7, 2000.

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